Approved Exception To SF 171
OMB No. 2900-0205
Estimated burden: 30 minutes

Department of Veterans Affairs

APPLICATION FOR RESIDENTS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER.

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. NAME (Last, First, Middle)	2. APPLICATION FOR (Check one) ☐ GENERAL PRACTICE ☐ SPECIALTY (Identify below)
3. PRESENT ADDRESS (Include ZIP Code)	4. TELEPHONE NUMBER (Include Area Code)
	4A. RESIDENCE / 4B. BUSINESS

5. DATE OF BIRTH	6. PLACE OF BIRTH	7. SOCIAL SECURITY NUMBER

8A. CITIZENSHIP ☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete Item 8B)	8B. COUNTRY OF WHICH YOU ARE A CITIZEN

9. DESIRED STARTING DATE OF RESIDENCY	10. ARE YOU A PARTICIPANT IN THE CURRENT NATIONAL RESIDENT MATCHING PROGRAM ☐ YES ☐ NO

11A. ARE YOU A DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS ☐ YES ☐ NO (IF "YES" COMPLETE ITEMS 11B AND 11C)	11B. NUMBER OF DIPLOMA	11C. DATE OF DIPLOMA

NOTE: Complete item 12A, 12B, 12C, or 12D, ONLY if you are not a U.S. citizen.

12A. IMMIGRANT	12B. EXCHANGE VISITOR		12C. OTHER NON-IMMIGRANT		12D. FORM IAP-66
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID FORM IAP-66 ☐ YES ☐ NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION

I – ACTIVE U.S. MILITARY DUTY

13A. DATE FROM	13B. DATE TO	13C. SERIAL OR SERVICE NO.	13D. BRANCH OF SERVICE	13E. TYPE OF DISCHARGE ☐ HONORABLE ☐ OTHER (Explain on separate sheet)

II – LICENSURE, DEA CERTIFICATION AND CLINICAL PRIVILEGES

14A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED (If not held now, explain on separate sheet)	14B. LICENSE NO.	14C. CURRENT REGISTRATION (If "NO" explain on separate sheet)			14D. EXPIRATION DATE
		YES	NO	NOT REQUIRED	

15. DO YOU HAVE OR HAVE YOU EVER HAD ANY LICENSE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED OR ISSUED/PLACED IN A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED ☐ YES ☐ NO (If "YES" explain on separate sheet)	16A. NUMBER OF CURRENT OR MOST RECENT DEA (DRUG ENFORCEMENT ADMINISTRATION) CERTIFICATE	16B. DATE OF EXPIRATION	17. HAVE YOU EVER HAD A DEA CERTIFICATE REVOKED, SUSPENDED, LIMITED, RESTRICTED IN ANY WAY, OR VOLUNTARILY RELINQUISHED ☐ YES ☐ NO (If "YES" explain on separate sheet)
18A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY ☐ YES ☐ NO (If "YES" complete Item 18B)	18B. NAME AND ADDRESS OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD		18C. HAVE ANY OF YOUR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, NOT RENEWED, OR VOLUNTARILY RELINQUISHED ☐ YES ☐ NO (If "YES" explain on separate sheet)

III – TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

CERTIFICATION: I certify that I have verified licensure and registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (If appropriate).

19. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:		OR
☐ NATURALIZED CITIZENSHIP	☐ FULL LICENSURE/REGISTRATION	☐ RESIDENT CREDENTIAL VERIFICATION LETTER
☐ VISA	☐ ECFMG CERTIFICATION	
	☐ CLERKSHIPS TAKEN IN THE U.S.	

20A. SIGNATURE OF FACILITY DIRECTOR OR DESIGNEE	20B. TITLE	20C. DATE